SmartCare Connect (Deputy Sheriff): Group Health

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kingcounty.gov/employees/benefits/YourKingCountyBenefits or by calling 206-684-1556.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For network providers **$1,000** person **/ $2,000 family** (gold level) **$1,500** person **/ $3,000** family (silver level) For out-of network providers **Limited emergency / out-of-area care**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Prescription drugs, premiums, balance-billed charges, benefit-specific coinsurance, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.ghc.org** or call 1-**888-901-4636** for a list of network providers.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term **network**, in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. See **www.ghc.org** or call 1-**888-901-4636** for a list of network providers.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see a **specialist**.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$ 7 (gold level) $20 (silver level)	Not covered.	————————none————————
	Specialist visit			
	Other practitioner office visit	$ 7 (gold level) $20 (silver level) for acupuncture, chiropractic and naturopathy	Not covered.	Coverage limited to 8 visits/medical diagnosis/year for acupuncture. Coverage limited to 3 visits/medical diagnosis/year for naturopathy, except for chiropractic.
	Preventive care/screening/immunization	No charge.	Not covered.	Provided according to well-child/adult preventive schedule.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	Not covered.	————————none————————
	Imaging (CT/PET scans, MRIs)	No charge.	Not covered	Preauthorization required to receive coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ghc.org.	Generic drugs	$ 5 (gold level) $10 (silver level) retail prescription $10 (gold level) $20 (silver level) mail-order prescription	Not covered.	Covers up to a 30-day supply (retail prescription) and 31-90 day supply (mail-order prescription through network only)
	Preferred brand drugs	$ 5 (gold level) $15 (silver level) retail prescription $10 (gold level) $30 (silver level) mail-order prescription	Not covered.	Covers up to a 30-day supply (retail prescription) and 31-90 day supply (mail-order prescription through network only)
	Non-preferred brand drugs	Not covered.	Not covered.	Covers up to a 30-day supply (retail prescription) and 31-90 day supply (mail-order prescription through network only)
	Specialty drugs	According to the generic, preferred and non-preferred drug categories	Not covered.	Covers up to a 30-day supply (mail-order prescription through network only)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	Not covered.	——————none——————
	Physician/surgeon fees	$ 7 (gold level) $20 (silver level)	Not covered.	——————none——————
If you need immediate medical attention	Emergency room services	$75 copay/visit (gold level) $100 copay/visit (silver level) emergency care	$125 copay/visit (gold level) $150 copay/visit (silver level) emergency care	Non-emergency care is not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Emergency medical transportation	20% coinsurance	20% coinsurance	————————none————————
	Urgent care	$ 7 (gold level) $20 (silver level)	$125 (gold level) $150 (silver level)	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	Not covered.	Preauthorization required to receive non-emergency inpatient services.
	Physician/surgeon fee	Included in facility fee.	Not covered.	Preauthorization required to receive non-emergency inpatient services.
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$ 7 (gold level) $20 (silver level)	Not covered.	————————none————————
	Mental/behavioral health inpatient services	No charge.	Not covered.	Preauthorization required to receive non-emergency inpatient services.
	Substance use disorder outpatient services	$ 7 (gold level) $20 (silver level)	Not covered.	————————none————————
	Substance use disorder inpatient services	No charge.	Not covered.	Preauthorization required to receive non-emergency inpatient services.
If you are pregnant	Prenatal and postnatal care	$ 7 (gold level) $20 (silver level)	Not covered.	————————none————————
	Delivery and all inpatient services	No charge.	Not covered.	Notification to Group Health required within 24 hours of admission or as soon as medically possible.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Preauthorization required to receive coverage.
	Rehabilitation services	$ 7 (gold level) $20 (silver level) outpatient care No charge for inpatient care.	Not covered.	Coverage limited to 60 outpatient visits/year and 60 inpatient days/year (combined limit applies to rehabilitation and habilitation).
	Habilitation services			
	Skilled nursing care	No charge.	Not covered.	Coverage limited to 60 days/year. Preauthorization required to receive coverage.
	Durable medical equipment	20% (gold level) 20% (silver level)	Not covered.	————————none————————
	Hospice service	No charge.	Not covered.	Preauthorization required to receive coverage. Limited to one period of continuous home care hospice service for one patient.
If your child needs dental or eye care	Eye exam	$ 7 (gold level) $20 (silver level)	Not covered.	Limited to 1 exam/person in 12-consecutive-month period.
	Glasses	Not covered.	Not covered.	————————none————————
	Dental check-up	Not covered.	Not covered.	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. See www.kingcounty.gov/employees/benefits.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 206-684-1556. You may also contact your state insurance department, the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Group Health at 1-888-901-4636 or visit www.ghc.org. For grievances and appeals regarding your drug coverage, call Group Health at 1-888-901-4636 or visit www.ghc.org. Additionally, a consumer assistance program can help you file your appeal. Contact the Washington Consumer Assistance Program at 800-562-6900 or cap@oic.wa.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,330
- **Patient at gold out-of-pocket level pays** $210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient at gold out-of-pocket level pays:

Deductibles	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$200
Total	**$210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,900
- **Patient at gold out-of-pocket level pays** $500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient at gold out-of-pocket level pays:

Deductibles	$0
Copays	$400
Coinsurance	$20
Limits or exclusions	$80
Total	**$500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending accounts (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.